MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2007

KAISER PERMANENTE INSURANCE COMPANY
300 Lakeside Drive 26th Floor
Oakland, CA 94612

NAIC Company Code 60053
NAIC Group Code 0901

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

KAISER PERMANENTE INSURANCE COMPANY
300 Lakeside Drive 26th Floor
Oakland, CA 94612

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2007

Examination Performed by:

State Market Conduct Examiners

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
David M. Tucker, AIE, FLMI, ACS
Violetta R. Pinkerton, CIE, MCM, CPCU, CPIW

And

Richard Kramer, CFE, AIE
Larry E. Cross, CFE, CIE

Independent Contract Examiners

February 13, 2009

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of Kaiser Permanente Insurance Company (the Company) was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, C.R.S., which authorize the Commissioner of Insurance to examine insurance companies. We examined the Company's records at its office located at 2500 South Havana Avenue, Aurora, Colorado, 80014. The market conduct examination covered the period from January 1, 2007, through December 31, 2007.

The following market conduct examiners respectfully submit the results of the examination.

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

Violetta R. Pinkerton, CIE, MCM, CPCU, CPIW

Richard Kramer, CFE, AIE

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TABLE OF CONTENTS

SECTION **PAGE**

COMPANY PROFILE

The following profile is based on information provided by the Company:

Kaiser Permanente Insurance Company (KPIC or Company) is a California-based company and obtained its license as a Life Insurance Company from the Colorado Secretary of State on September 6, 1996.

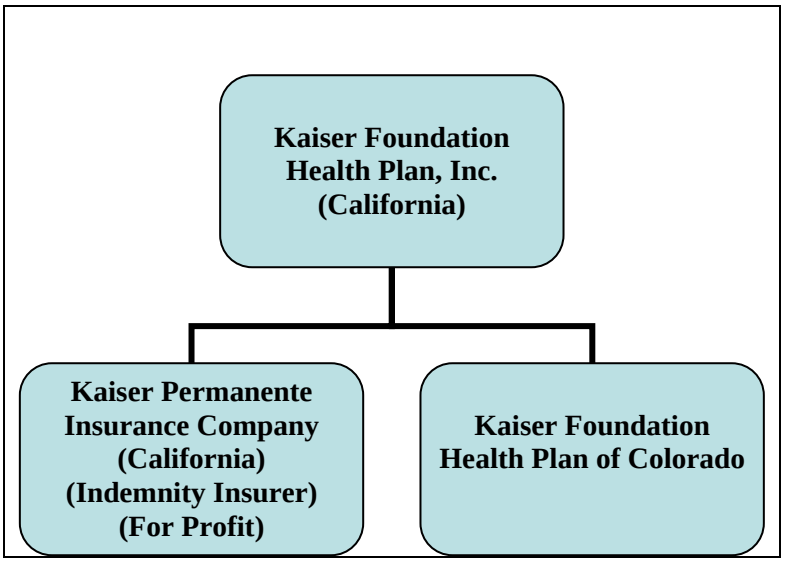
Kaiser Foundation Health Plan of Colorado (KFHP) and KPIC jointly underwrite a three-tier point-of-service product in the KFHP-Colorado (Denver/Boulder) service area. KPIC also underwrites PPO and Indemnity plans in support of KFHP-Colorado (Denver/Boulder) market needs. The lives covered by this product as of 01/01/07 and 07/31/07 are as follows:

Product Type	01/01/07	07/31/07
POS	13,656	12,137
PPO	949	986
Indemnity	25	19
Total	14,630	13,142

KPIC has executed an administrative services agreement with KFHP-CO for certain administrative services, including claims adjudication, in support of all three product lines. KPIC administrative services are provided by dedicated teams of claim processors and customer service representatives. Claim payment audits, which including financial, processing, and procedural accuracy, are self-reported by the Colorado Region to KPIC on a monthly basis. Once a year, KPIC validates the self-reported results with an independent audit of a statistically valid random sampling of claims."

Kaiser Permanente Insurance Company's NAIC Company Code is 60053 and its NAIC Group Code is 601.

Written Premium as of 12/31/07 (in 1000's):	$31,958
Market Share (all Colorado Accident & Health):	0.36%



PURPOSE AND SCOPE

State market conduct examiners with the Colorado Division of Insurance, (Division), who were assisted by independent contract examiners, reviewed certain business practices of Kaiser Permanente Insurance Company (the Company). The limited market conduct examination was performed in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, C.R.S., which empower the Commissioner to examine any entity engaged in the business of insurance. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws related to health insurance companies. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

The examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or submitted by the Company. The limited market conduct examination covered the period from January 1, 2007, through December 31, 2007.

The examination included review of the following:

Company Operations and Management
Contract Forms
New Business Application and Renewal Underwriting
Rating
Cancellations/Declinations/Termination/Rescissions
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain any improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to individual, small and large group health insurance laws. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-8-513, C.R.S.	Eligibility for coverage under the program.
Section 10-8-521, C.R.S.	Notice to residents.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-103.5, C.R.S.	Payment of Premiums – required term in contract.
Section 10-16-104, C.R.S.	Mandatory coverage provisions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age.
Section 10-16-105, C.R.S.	Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee – repeal.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-106.7, C.R.S.	Assignment of health insurance benefits.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modification of health benefit plans.
Section 10-16-214, C.R.S.	Group sickness and accident insurance.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, commercial Automobile with Individually-owned Private Passenger Automobile-Type Endorsement Forms, Claims-made Liability Forms and Preneed Funeral Contracts
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-6	Concerning the Definition of the Term "Complications of Pregnancy" for Use in Accident and Health Insurance Contracts and Certificates
Insurance Regulation 4-2-8	Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance

Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation Of Health Plan Claims Involving Utilization Review
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-6-2	Group Coordination of Benefits
Insurance Regulation 4-6-5	Concerning Implementation of Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-8	Concerning Small Employer Health Plans
Insurance Regulation 4-6-9	Conversion Coverage
Insurance Regulation 4-7-2	Concerning the Laws Regulating Health Maintenance Organization Benefit Contracts and Services in Colorado

Company Operations and Management

The examiners reviewed Company management and administrative controls, the certificate of authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company has not been the subject of a previous market conduct examination in Colorado.

Contract Forms

The examiners reviewed the following forms that are used in conjunction with Kaiser Foundation Health Plan of Colorado's "Triple Option" plans:

- The Company's most commonly sold PPO and POS group certificates;
- The Company's PPO and POS conversion certificates, application/enrollment forms, and supporting documents; and
- The Company's group and employee PPO and POS applications/enrollment forms and supporting documents

These plans and related documents were issued and/or certified with the Division between January 1, 2007 and December 31, 2007.

New Business Applications and Renewals

The examiners reviewed:

- A sample of fifty (50) small group new business application files;
- A sample of fifty (50) small group renewal files; and
- The Company's rating practices as it pertains to small group new business applications and renewal files in the above samples.

Cancellations/Declinations/Terminations

The examiners reviewed:

- A sample of fifty (50) small group cancellation files; and
- A sample of fifty (50) small group declination files.

Claims

In order to determine the Company's compliance with Colorado's prompt payment of claims law and the proper and accurate payment of claims, the examiners reviewed the following random samples:

- One hundred (100) paid claims;
- Fifty (50) denied claims;
- Fifty (50) electronic claims paid, denied or settled beyond thirty (30) days from claim received date;
- Thirty-one (31) non-electronic claims paid, denied or settled beyond forty-five (45) days from claim received date;
- Seven (7) claims paid, denied or settled beyond ninety (90) days from claim received date.

Utilization Review

The examiners reviewed the Company's utilization management program including policies and procedures. The examiners selected a random sample of fifty (50) utilization review (UR) approval decision files from a summarized population of 1,138 and the entire population of seventeen (17) UR denial decision files. These sample files were reviewed for the Company's overall UR handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons in order to determine compliance with Colorado insurance law.

In addition, the examiners reviewed the entire population of two (2) first level appeal files in order to determine compliance with Colorado insurance law. The Company had no second level or external appeal files to review.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of fifteen (15) findings in which the Company did not appear to be in compliance with Colorado insurance laws. The following is a summary of the examiners' findings.

Operations and Management: The examiners identified one (1) area of concern in their review of the Company's operations/management:

Issue A1: Failure, in some instances, to maintain and to provide, upon request, records and documents required for market conduct purposes.

Contract Forms: The examiners identified nine (9) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and riders):

Issue E1: Failure of the Company's forms, in some instances, to provide coverage for a newborn or adopted dependent to the extent required by Colorado insurance law.

Issue E2: Failure, in some instances, to include correct eligibility requirements in the certificate of insurance.

Issue E3: Failure of the Company's forms, in some instances, to include Medicare eligible employees as being eligible for coverage.

Issue E4: Failure of the Company to properly define termination requirements in its membership agreements.

Issue E5: Failure of the Company to include a provision for coordination of benefits with Medicare that complies with Colorado insurance law.

Issue E6: Failure of the Company's forms, in some instances, to reflect correct information regarding eligibility for conversion coverage.

Issue E7: Failure of the Company to properly define an eligible dependent.

Issue E8: Failure of the Company to properly allow for assignment of benefits.

Issue E9: Failure of the Company to properly define pre-authorization procedures.

New Business Application and Renewal Underwriting: The examiners identified no areas of concern in their review of the Company's underwriting practices.

Cancellation/Declinations/Terminations: The examiners identified two (2) areas of concern in their review of the Company's cancellation/declination/termination practices:

Issue H1: Failure of the Company's Certificates of Creditable Coverage to reflect the full definition of a "significant break in coverage".

Issue H2: Failure of the Company's certificates of creditable coverage to disclose the name of the entity that provided coverage.

Claims: The examiners identified three (3) areas of concern in their review of the claims handling practices of the Company:

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

Issue J2: Failure, in some instances, to pend unclean claims and to allow the required time for submission of additional information before denying.

Issue J3: Failure, in some instances, to provide notice of appeal rights on denied claims.

Utilization Review: The examiners identified no areas of concern in their review of the Company's Utilization Review procedures.

A copy of the Company's response, if applicable, can be obtained by contacting the Company. Results of previous market conduct examinations (if any) are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

KAISER PERMANENTE INSURANCE COMPANY

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure, in some instances, to maintain and to provide, upon request, records and documents required for market conduct purposes.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under authority of Section 10-1-109(1), C.R.S., states in part:

Section 3. Definitions

A. *"Application records" mean* any written or electronic application form, any enrollment form, any document used to add coverage under an existing policy, any questionnaire, telephone interview form, paramedical interview form, *or any other document used* to question *or underwrite an applicant for a policy issued by an insurer* or for any declination of coverage by an insurer. [Emphases added.]

Section 4. Records Required For Market Conduct Purposes

A. *Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations, including but not limited to,* company operations and management, policyholder services, claims practices, *rating, underwriting,* marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two calendar years. [Emphases added.]

Section 5. Policy Records

A. The following records shall be maintained: A policy record shall be maintained for each policy issued. *Policy record shall be maintained so as to show clearly the policy period, basis for rating* and any imposition of additional exclusions from or exceptions to coverage. If a policy is terminated, either by the insurer or the policyholder, documentation supporting the termination and account records indicating a return of premiums, if any, shall also be maintained. Policy records need not be segregated from the policy records of another state so long as records are readily available to market conduct examiners as required under this regulation.

B. *Policy records shall include at least the following*:

(1) *The actual, completed application for each contract,* where applicable;

(a) *The application shall bear the signature, either written or digitally authenticated, where required, of the applicant* whenever the insurer

intends to retain any right to contest any warranty, representation or condition contained in the application; or

(2) Any declaration pages (the initial page and any subsequent pages), the insurance contract, any certificates evidencing coverage under a group contract, any endorsements or riders associated with a policy, any termination notices, *and any written or electronic correspondence to or from the insured pertaining to the coverage. A separate copy of the record need not be maintained in the individual policy to which the record pertains, provided* it is clear from the insurer's other records or systems that the record applies to a particular policy and *that any data contained in the record relating to the a policy, as well as the actual policy, can be retrieved or recreated;* [Emphases added.]

Section 9. Format of Records

A. *Any record required to be maintained by an insurer may be in the form of paper, photograph, magnetic, mechanical or electronic medium; or any process that accurately forms a durable reproduction of the record, so long as the record is capable of duplication to a hard copy that is as legible as the original document.* Documents that are produced and sent to an insured by use of a template and an electronic mail list shall be considered to be sufficiently reproduced if the insurer can provide proof of mailing of the documents and a copy of the template. *Documents that require the signature of the insured or insurer's producer shall be maintained in any format listed above, provided evidence of the signatures is preserved in that format.*

B. The maintenance of records in a computer-based format shall be archival in nature, so as to preclude the alteration of the record after the initial transfer to a computer formation. *Upon request of an examiner, all records shall be capable of duplication to a hard copy that is as legible as the original document.* The records shall be maintained according to written procedures developed and adhered to by the insurer. The written procedures shall be made available to the commissioner's market conduct examiners in accordance with Section 12. [Emphases added.]

Section 10. Location of Records

A. *All records required to be maintained under this regulation shall be kept in a location or locations that will allow the records to be produced for examination within the time period required under Section 11.*

Section 12. *Records Usually Required for Examination*

F. Underwriting and rating practices: annual rate filing, company rating plan and rates, disclosure, producer payments, credits, deviations, schedule rating, IRPM plans, expense/loss cost multipliers, statistical coding/reporting, premium audits, loss reporting, policy forms and filings, underwriting policies, procedures, and manuals, declinations/rejections, cancellations/renewals, rescissions, *policyholder records* (*applications*,

> policy riders, *correspondence,* policy forms), guaranteed issue, pre-existing conditions and privacy of protected personal information. [Emphases added.]

SMALL GROUP APPLICATION FILES

Population	Sample Size	Number of Exceptions	Percentage to Sample
111	50	38	76%

Using ACL™ software, the examiners requested a random sample of fifty (50) small group application files. It appears the Company is not in compliance with Colorado insurance law in that it was unable to provide copies of numerous pieces of information required to be maintained in employer application files.

Specifically, the Company was unable to provide sixteen (16) small group applications; thirteen (13) employee census lists; thirty-eight (38) employee applications; and thirty-eight (38) employee waivers in the sample of fifty (50) small group application files reviewed.

Colorado insurance law requires the Company to retain these documents, accurately reproduce them and make them available for review during a market conduct examination.

Recommendation No. 1

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 1-1-7. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that they meet the record retention requirements required by Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure of the Company's forms, in some instances, to provide coverage for a newborn or adopted dependent to the extent required by Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn children

(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(d) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of the newborn child and payment of the required premium must be furnished to the insurer or other entity within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period. [Emphasis added.]

(e) The requirements of this section shall apply to all individual sickness and accident policies issued on and or after July 1, 1975, and to all blanket and group sickness and accident policies issued, renewed, or reinstated on and after July 1, 1975, and to all subscriber or enrollee coverage contracts delivered or issued for delivery in this state on and after July 1, 1975.

(6.5) Adopted child - dependent coverage**.**

(a) Whenever an entity described in paragraph (a) of subsection (6) of this section offers coverage for dependent children under a health plan, *the entity* shall provide benefits to a child placed for adoption with an enrollee, policyholder, or subscriber *under the same terms and conditions that apply to a natural dependent of an enrollee, policyholder, or subscriber*, regardless of whether adoption of the child is final. [Emphasis added.]

It appears the Company is not in compliance with Colorado insurance law in that its certificate of coverage form requires enrollment of newborn and newly adopted children within thirty-one (31) days in order for coverage to continue beyond thirty-one (31) days even if the subscriber already has family coverage and no additional premium would be required to add the additional child. While the subsequent paragraph references a cost increase to add the child, it is not clear that the coverage continues without the child being specifically enrolled within thirty-one (31) days if the subscriber already has family coverage and no additional premium would be required to add the additional child.

The Company's form states, in part:

Coverage for Newborns

A newborn Dependent child is insured from birth. *You must enroll the newborn dependent for insurance and pay any additional cost within thirty-one (31) days of that Dependent's birth in order for insurance to extend coverage beyond the 31-day period.* If coverage terminates at the

expiration of the 31-day period, the child will be considered a Late Enrollee. Late Enrollees may be excluded from all coverage for a period of up to twelve (12) months. . [Emphasis added.]

If the cost of Your coverage would not increase as a result of the child being enrolled under the coverage, You should still notify Us, in writing of the child's birth within thirty-one (31) days.

This will allow Us to add the child to Our records and help avoid delays in any claim You might file on behalf of the child.

Coverage for Adopted Children

Your adopted child is insured from the earlier of the date of adoption or the date of Placement for Adoption. *You must enroll the adopted child for insurance and agree to pay any additional cost within thirty-one (31) days of the child's eligibility date in order for insurance to extend beyond the 31-day period.* If coverage terminates at the expiration of the 31-day period, the child will be considered a Late Enrollee. Late Enrollees may be excluded from all coverages for a period of up to twelve (12) months. (Emphasis added.)

If the cost of Your coverage would not increase as a result of the child being enrolled under the coverage, You should still notify Us, in writing of the child's adoption or Placement for Adoption within thirty-one (31) days. This will allow Us to add the child to Our records and help avoid delays in any claim You might file on behalf of the child.

Colorado insurance law does not allow the Company to consider a newborn or newly adopted child as a late enrollee and exclude from coverage if the subscriber already has family coverage even though the child may not have been enrolled within thirty-one (31) days of the birth or placement for adoption.

Colorado law allows the Company to terminate coverage for a newborn or newly adopted child after the first thirty-one (31) days if the subscriber has other than family coverage (i.e. subscriber + spouse only) if said enrollment would result in an additional premium and such premium is not paid within thirty-one (31) days after the birth or placement of the child for adoption.

Form:	Date:
CO-POS-2007	2007

Recommendation No. 2

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly disclose the required coverage for newborn and newly adopted dependents mandated by Colorado insurance law.

Issue E2: Failure, in some instances, to include correct eligibility requirements in the certificate of insurance.

Section 10-16-102, C.R.S. Definitions, states, in part:

> (15)(a) "Eligible employee" means an employee who has a regular work week of twenty-four or more hours and includes a sole proprietor and a partner of a partnership if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis.

Section 10-16-105, C.R.S., Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic health benefit plans - rules - benefit design advisory committee – repeal, states, in part:

> (7.6)(a) No small employer carrier is required to accept applications from or offer coverage pursuant to paragraph (a) of subsection (7.3) of this section:
>
> (II) To an employee, when the *employee does not work or reside within the small employer carrier's established geographic area*; or [Emphasis added.]

Colorado Insurance Regulation 4-6-8, Concerning Small Employer Health Plans

> Section 5. Issuance of Coverage
>
> (2) A small employer carrier shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. For managed care plans, an employee must *either work or reside in the carrier's service area* to be considered an eligible employee, except as provided in Section 10-16-704(2)(g), C.R.S. [Emphasis added.]

It appears the Company is not in compliance with Colorado insurance law in that the certificate of insurance for its triple option POS plan, (Colorado Added Choice Coverage), limits eligibility for participation in its PPO option to employees who live in the PPO service area. Under Colorado insurance law, eligibility for small group coverage may not be limited to employees who live in the established geographic area. An employee who resides outside the established geographic area but works within the established geographic area should be eligible.

The Company form states, in part:

GENERAL DEFINITIONS

> **Participating Provider Organization (PPO)** means a KPIC indemnity plan type, in which Covered Persons have access to a network of contracted providers and facilities referred to as preferred providers. In most instances, a higher level of benefits applies to Covered Services received from preferred providers and facilities. *In order to participate in the PPO, the Covered Person must live within the PPO service area, defined as at least 30 miles from a provider listed in the PPO Provider Directory.* The Schedule of Coverage shows the plan type under which the Covered Person is insured. [Emphasis added.]

Form:	Date:
CO-POS-2007	2007

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102 and 10-16-105, C.R.S. and Colorado Insurance Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly reflect employee eligibility requirements in accordance with Colorado insurance law.

Issue E3: Failure of the Company's forms, in some instances, to include Medicare eligible employees as being eligible for coverage.

Section 10-16-102, C.R.S. Definitions, states, in part:

> (15)(a) "Eligible employee" means an employee who has a regular work week of twenty-four or more hours and includes a sole proprietor and a partner of a partnership if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee – repeal, states in part:

> (7.5)(a) Effective January 1, 2004, if a small employer carrier offers coverage to a small employer, such small employer carrier shall offer the group coverage to all of the eligible employees of the small employer and their dependents. A small employer carrier shall not offer coverage to only certain eligible individuals in a small employer group or to only a part of the group, except in the case of the late enrollees as provided in Section 10-16-118, (1)(c).

It appears the Company is not in compliance with Colorado insurance law in that the certificate of insurance for its triple option POS plan, (Colorado Added Choice Coverage), limits eligibility for participation in its POS plan to employees that are not eligible for Medicare.

The limitation is contrary to the definition of eligible employee under Colorado insurance law, as well as the requirement to offer group coverage to all of the small group's eligible employees. If an HMO offers a POS plan to a small employer, it must be offered to all eligible employees of that small group regardless of whether the eligible employees may also be eligible for Medicare.

The Company's forms state, in part:

GENERAL DEFINITIONS

> **Eligible Employee** means a person, who at the time of original enrollment: (a) is working for a Policyholder as a full-time employee as described below or is entitled to coverage under an employment contract; (b) by virtue of such employment or contract enrolls under the Group Policy and (c) reached an eligibility date. Eligible Employee includes sole proprietors, partners of a partnership, or independent contractor if they are included as employees under a health benefit plan of the Policyholder, engaged on a full-time basis in the employer's business or are entitled to coverage under an employment contract.
>
> The term Eligible Employee does not include the following:
>
> 1. A person who is *eligible* for Medicare Part A or Medicare Part B, except that this does not apply to those entitled to Medicare benefits who under federal law elect, or are required, to have the Policyholder's health coverage as their primary health coverage; or [Emphasis added.]

Form:	Date:
CO-POS-2007	2007

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-102 and 10-16-105, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly reflect all employees eligible for coverage in accordance with Colorado insurance law.

Issue E4: Failure of the Company to properly define termination requirements in its membership agreements.

Section 10-16-102, C.R.S., Definitions, states, in part:

(15)(a) "Eligible employee" means an employee who has a regular work week of twenty-four or more hours and includes a sole proprietor and a partner of a partnership if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis.

Section 10-16-105, C.R.S., Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic health benefit plans - rules - benefit design advisory committee – repeal, states, in part:

(3) A small group sickness and accident insurance plan, small group plan, or small group policy shall be renewable to all eligible employees and dependents at the option of the small employer, except as allowed pursuant to section 10-16-201.5.

(7.6)(a) No small employer carrier is required to *accept applications from or offer coverage* pursuant to paragraph (a) of subsection (7.3) of this section:

(II) To an employee, when the *employee does not work or reside within the small employer carrier's established geographic area*; or... [Emphases added.)

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states, in part:

(1) A carrier providing coverage under a health benefit plan *shall not discontinue coverage or refuse to renew such plan except for the following reasons:* [Emphasis added.]

(a) Nonpayment of the required premium;

(b) Fraud or intentional misrepresentation of material fact on the part of the plan sponsor with respect to group health benefit plan coverage and the individual with respect to individual coverage;

(d)(I) The carrier elects to discontinue offering and nonrenews all of its individual, small group or large group health benefit plans delivered or issued for delivery in this state.

(g) With respect to group health benefit plans, the policyholder fails to comply with participation or contribution rules;

(h) With respect to a carrier that offers group health benefit plans in the market through a managed care plan, there is no longer any enrollee

in connection with such plan that lives, resides, or works in the service area of the carrier;

(i) With respect to small group health benefit plans, an employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan; or

(j) With respect to coverage of an employer that is made available only through one or more bona fide associations, the membership of an employer ceases.

Colorado Insurance Regulation 4-6-8, Concerning Small Employer Health Plans, states in part:

Section 5. Issuance of Coverage

(2) A small employer carrier shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. For managed care plans, an employee must *either work or reside in the carrier's service area* to be considered an eligible employee, except as provided in Section 10-16-704(2) (g), C.R.S. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that the certificate of insurance for its triple option POS plan, (Colorado Added Choice Coverage), provides that the coverage of individual employees or employees' dependents currently enrolled and otherwise eligible for coverage, will be terminated if the employees or employees' dependents relocate to a place outside the geographic service area or when a Member becomes eligible for Medicare benefits.

Colorado insurance law does not allow termination of a covered employee or an employee's dependent solely because the employee or employee's dependent *resides* outside the geographic service area, if the employee continues to *work* within the geographic service area or vice versa. [Emphasis added.]

Colorado insurance law also does not allow termination of a covered employee or employee's dependents solely because the employee becomes eligible for Medicare. Eligibility for Medicare is not one of the allowed reasons for termination of coverage.

The Company's form states in part:

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

Eligibility

Termination of a Covered Person's Insurance

Except as provided in the Continuation of Medical Benefits or Extension of Benefits provisions, the Covered Person's insurance will automatically terminate on the earlier of the following dates:

6. *The date the employee or employee's Dependents relocate to a place outside of the geographic service area of the provider network, if applicable*; or [Emphasis added.]

COORDINATION OF BENEFITS

Effect of Medicare

This Plan will be primary to Medicare for an active employee and Dependent spouse of such active employee. This Plan will not be primary to Medicare if the Covered Person is *eligible for Medicare* as primary. *Any such Covered Person may not continue enrollment under This Plan. Medicare is primary for an insured retiree or the Dependent Spouse of a retiree age 65 or over; this applies whether or not the retiree or spouse is enrolled in Medicare*. [Emphasis added.]

Form:	Date:
CO-POS-2007	2007

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-102 and 10-16-201.5, C.R.S. and Colorado Insurance Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to reflect allowable termination provisions in accordance with Colorado insurance law.

Issue E5: Failure of the Company to include a provision for coordination of benefits with Medicare that complies with Colorado insurance law.

Colorado Insurance Regulation 4-6-2, Concerning Group Coordination of Benefits, states in part:

Section 4. Definitions

H. "Plan" means a form of coverage with which coordination is allowed or required. …

(3) Plan may include:

(h) Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4)(i) below. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

Section 5. Use of Model COB Contract Provision

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

(2) *A person is or could have been covered under another plan, except with respect to Part B of Medicare; or*

E. *No plan may contain a provision that its benefits are "always excess" or "always secondary" except in accord with the rules permitted by this regulation.* [Emphases added.]

Section 6. Rules for Coordination of Benefits

D. Order-of-Benefit Determination

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

(1) Non-Dependent or Dependent

The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person, as a dependent is secondary. *However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:*

(a) Secondary to the plan covering the person as a dependent; and

(b) Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary. [Emphases added.]

Colorado Insurance Regulation 4-7-2, Concerning The Laws Regulating Health Maintenance Organization Benefit Contracts And Services In Colorado, states in part:

> Section 4. Definitions
>
> J. "Point-of-service plan contract" means a Health Maintenance Organization contract which includes coverage for both in-network services and coverage for services provided by non-contracted providers. *The term "point-of-service plan contract" shall also apply to a plan contract where the indemnity coverage or service is underwritten by a non-HMO carrier in this state and is offered in conjunction with an HMO contract.* [Emphasis added.]
>
> Section 5. Requirements for Benefit Contracts and Evidences of Coverage
>
> L. Coordination of Benefits
>
> *A group contract and/or evidence of coverage must contain a provision for coordination of benefits that shall be consistent with Colorado Insurance Regulation 4-6-2, 3 CCR 702-4.*…[Emphasis added.]

It appears the Company is not in compliance with Colorado insurance law in that the certificate of insurance for its triple option POS plan, (Colorado Added Choice Coverage), contains a coordination of benefits provision that is not in compliance with the above Regulation. The statement does not include all the criteria required by the Medicare Secondary Payor Rules (MSR Rules). Further, the coordination of benefits statement implies that criteria it contains and the result of applying that criteria are always the same, with no variation. The Company's certificate of insurance coordination of benefits statement regarding Medicare is therefore not correct.

Specifically, the certificate includes no reference to the different secondary payor rules regarding employers with less than 20 employees, disabled employees and employees with End Stage Renal Disease. The statement regarding retired employees and Dependent spouse of a retiree is also incorrect. A retired employee who is not enrolled in Medicare is not entitled to Medicare and Medicare is primary only if the retired employee is entitled to Medicare.

Colorado insurance law prohibits using a coordination of benefits provision to reduce benefits on the basis that a person is or could have been covered under another plan. Colorado insurance law further prohibits a plan from including a statement that its benefits are "'always excess" or "always secondary" except in accord with the rules permitted by Regulation 4-6-2. By not including the varying criteria of the MSR Rules, the Company implies that the payor status as stated is always the case.

The Company's forms state in part:

COORDINATION OF BENEFITS

Effect of Medicare

This Plan will be primary to Medicare for an active employee and Dependent spouse of such active employee. This Plan will not be primary to Medicare if the Covered Person is eligible for Medicare as primary. Any such Covered Person may not continue enrollment under This Plan.

Medicare is primary for an insured retiree or the Dependent Spouse of a retiree age 65 or over; this applies whether or not the retiree or spouse is enrolled in Medicare. [Emphasis added.]

Form:	Date:
CO-POS-2007	2007

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulations 4-6-2 and 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly reflect the required Coordination of Benefits provisions as they relate to Medicare in accordance with Colorado insurance law.

Issue E6: Failure of the Company's forms, in some instances, to reflect correct information regarding eligibility for conversion coverage.

Section 10-16-102, C.R.S., Definitions, states in part:

(15)(a) *"Eligible employee" means an employee who has a regular work week of twenty-four or more hours* and includes a sole proprietor and a partner of a partnership if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis. [Emphasis added.]

Section 10-16-108, C.R.S., Conversion and continuation privileges, states, in part:

(1) Group sickness and accident insurance – conversion privileges.

(d)(I) *A converted policy issued upon the exercise of the conversion privilege of paragraph (c) of this subsection (1) shall offer a choice of a basic or standard health benefit plan.*

(XV)(A) An employee or member who is entitled to make application for a converted policy pursuant to the provisions of paragraph (c) of this subsection (1) *shall be given written notice of the existence of the conversion privilege at least fifteen days prior to the expiration of the thirty-one-day conversion period established by the group policy. If the employee or member is not given notice of his conversion rights, the employee or member shall have an additional period within which to exercise such conversion privilege. This additional period shall expire fifteen days after the employee or member has been given such notice,* but in no event shall the additional period be continued for more than sixty days after the expiration of the thirty-one-day period established by the group policy.

(B) Written notice presented to the employee or member by the policyholder or mailed by the policyholder to the last-known address of the employee or member, as furnished to the policyholder, shall constitute the giving of notice for the purpose of this provision. *If an employee or member is permitted an additional period for conversion, as provided in this subparagraph (XV), and if written application for the converted policy, accompanied by the initial premium, is made within the additional period, the effective date of the converted policy shall be the day following the employee's or member's termination of insurance under the group policy.* [Emphases added.]

Colorado Insurance Regulation 4-6-8, Concerning Small Employer Health Plans, promulgated pursuant to §§ 10-10-109(1), 10-16-105.2(1)(a)(IV) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, and 10-16-708, C.R.S., states in part:

Section 5. Issuance of Coverage

B. Determining Who is an Eligible Employee, Dependent

1. The Colorado Division of Insurance finds that, when defining "eligible employee" in Section 10-16-102(15), C.R.S., the sole intent of the General Assembly was to create a maximum weekly work requirement which small employer carriers may impose as a requirement for an employee's participation in a health benefit plan. Nothing in the definition of "eligible employee" was intended to limit an employer's traditional ability to set valid and acceptable standards for employee eligibility based upon the terms and conditions of employment, including a minimum weekly work requirement in excess of twenty-four (24) hours and eligibility based upon salaried versus hourly workers and management versus non-management employees.

2. The Division finds that, subject to other statutory restrictions and the provisions of this regulation, a small employer carrier may offer a health benefit plan to the eligible employees of a small employer as that small employer defines its eligible employees (herein after referred to as "employer-determined eligible employees"). However, a carrier must offer coverage to all small employers *for all employees with a regular work week of at least 24 hours on a regular basis.* The decision of a small employer to limit eligibility for coverage as provided for in subparagraph (1) of this subsection B shall be solely at the small employer's discretion, without direct or indirect pressure or suggestion by the carrier, producer, or their representatives. The small employer carrier may offer coverage only to such employer-determined eligible employees and their dependents and may apply its minimum participation and contribution criteria solely to such employer-determined eligible employees. [Emphasis added.]

Colorado Insurance Regulation 4-6-9, Concerning Conversion Coverage, promulgated pursuant to §§ 10-1-109(1) and 10-16-109, C.R.S., states in part:

Section 5. Choice of Basic or Standard Health Benefit Plans

A. *All persons entitled to elect conversion coverage pursuant to Sections 10-16-108(1)(c), or 10-16-108(2)(d) and 10-16-108(4), C.R.S., shall be offered a choice of the basic and standard health benefit plans only.* (The basic and standard health benefit plans and rules for their implementation are described in Colorado insurance regulation No. 4-6-5, C.C.R.)

B. *All persons entitled to elect conversion coverage pursuant to Section 10-16-108(4), C.R.S., shall be offered a choice of the basic and standard health benefit plans only, except that, pursuant to Section 10-16-108(4)(b), C.R.S., a small employer carrier may offer as conversion coverage the basic health benefit plan*

only (instead of a choice of the basic or the standard health benefit plan) if all the following conditions are met:

1. The applicant for conversion coverage is eligible for conversion coverage pursuant to Section 10-16-108(4)(b), C.R.S., but is not eligible for conversion coverage under Section 10-16-108(1)(c) or (2)(a), C.R.S., and

2. The small employer health benefit plan from which the applicant is converting had benefits which provided coverage for hospital and physician services which, in most respects, were significantly less generous than the standard plan and comparable to or less generous than the basic health benefit plan.

C. *A carrier shall, at a minimum, offer to an applicant for conversion coverage at least one basic conversion coverage health benefit plan and at least one standard conversion health benefit plan of the same type (i.e., traditional indemnity, preferred provider or health maintenance organization) as the coverage from which the applicant is converting.* Carriers may also offer the other types of standard and basic health benefit plan conversion coverage to applicants. If a carrier offers several preferred provider or health maintenance organization plans, it may meet this requirement by offering the most managed care version of its preferred provider plans and the most managed care version of its health maintenance organization plans. For the purposes of this subsection B, "most managed care version" is that plan which, when compared to the carrier's other preferred provider plans or HMOs offers the consumer the greatest financial incentive for the utilization of network participating providers.

D. *Carriers shall not offer other conversion coverage policies either in addition to or in lieu of the basic and standard health benefit plans.* Conversion coverage under the basic and standard health benefit plans shall not be modified in any way except that carriers may offer optional riders to the basic or standard health benefit plans which would add additional coverage, so long as such coverage is offered to all applicants for conversion coverage and guarantee issued to any such person requesting additional coverage. [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that the certificate of insurance for its triple option POS plan, (Colorado Added Choice Coverage):

- provides that the application and first premium for a conversion health policy must be mailed within thirty-one (31) days after the date the covered person's coverage under the plan ceases;

- provides that the individual health policy will be of a type that the Company issues without indicating the conversion policy will be a basic or standard health plan, and;

- requires evidence of insurability from an individual who again becomes a covered person under this plan after being issued a conversion policy.

Colorado insurance law provides that if the covered person is not given timely notice of the right of conversion, the covered person shall have an additional time period within which to exercise such conversion privilege. Colorado law allows only the offer of basic and standard health policies as conversion coverage, and requires small employer carriers to offer coverage to all eligible employees of a small employer. A small employer carrier may not require submission of individual evidence of insurability if a person insured under a conversion policy again becomes eligible to be covered under the group plan.

The Company's form states in part:

CONVERSION

Issuance of an individual health policy will be subject to the following conditions:

1. Written application for conversion and the first premium for the individual health policy *must be mailed within 31 days after the date the Covered Person's coverage under the plan ceased*;
2. The individual health policy will be of the type issued by US at our then current rates; and
3. The policy will become effective the day after the date on which coverage under the plan ceases.

A person issued an individual KPIC policy may again become a Covered Person under This Plan providing he or she submits evidence of insurability. [Emphases added]

Form:	Date:
CO-POS-2007	2007

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§10-16-102 and 10-16-108, C.R.S. and Colorado Insurance Regulations 4-6-8 and 4-6-9. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to reflect correct information relating to conversion policies in accordance with Colorado insurance law.

Issue E7: Failure of the Company to properly define an eligible dependent.

Section 10-16-102, C.R.S. Definitions, states in part:

> (14) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

Section 10-16-104.3, C.R.S., Dependent health coverage for persons under *twenty-five* years of age, states in part:

> (1) All individual and group sickness and accident insurance policies providing coverage within the state by an entity subject to the provisions of part 2 of this article and *all group health service contracts issued by an entity subject to the provisions of part 3 or 4 of this article that offer dependent coverage shall offer to the parent, for an additional premium if applicable, by rider or supplemental policy provision, the same dependent coverage for an unmarried child who is under twenty-five years of age, and is not a dependent as defined by section 10-16-102 if such child:*
>
> *(a) Has the same legal residence as the parent; or*
>
> *(b) Is financially dependent upon the parent*. [Emphases added]

It appears the Company is not in compliance with Colorado insurance law in that the certificate of insurance for its triple option POS plan, (Colorado Added Choice Coverage), which incorporates the schedule of coverage by reference:

- limits coverage for non-student dependents under age nineteen (19) to those who are financially dependent on the employee or employee's spouse,
- requires student dependents over age nineteen (19) and under age twenty-four (24) to be enrolled as a full-time student each year after reaching age nineteen (19) to be eligible for coverage, and
- requires dependents up to age twenty-five (25) to be students to be eligible for coverage.

In addition, the Company's large group enrollment/change form does not appear to be in compliance in that its instructions for completion include an incorrect statement that the plan covers children only up to a certain age, unless the child is disabled or a full-time student at a college, university, or trade school.

Colorado insurance law does not require financial dependency for dependents under age nineteen (19) and requires only that dependents over age nineteen but under age twenty-four (24) be currently enrolled as a full-time student to be eligible for coverage. Colorado insurance law provides that dependents up to age twenty-five (25) are eligible for coverage if the dependent either resides with the parent or is financially dependent upon the parent. Colorado insurance law does not require that a dependent over the age of twenty-four (24) but under the age of twenty-five (25) be a student to be eligible for coverage.

The Company provided, in addition to its certificate of coverage, two examples of a schedule of coverage to illustrate the age limit for dependents as typically provided. The Company also provided large and small group applications as well as copies of the small group uniform employee application and the large group enrollment/change form.

The Company's forms state in part:

GENERAL DEFINITIONS

Dependent means:
1. Your lawful spouse or Domestic Partner; or
2. Your or Your spouse's unmarried natural or adopted child, if that child is:
   a. Living with You or living away from You due to divorce decree or living away from home as a full-time student;
   b. Financially dependent on You for support; and
   c. Either;
      (1) A Dependent child of an age within the age limit for a child shown in the Schedule of Coverage; or
      (2) A Dependent child of an age within the age limit for a student shown in the Schedule of Coverage and, in each Calendar Year since reaching the child age limit, has been enrolled as a full-time student at an accredited vocational school, college, or university, or
      (3) Your unmarried child of any age who is medically certified as disabled and dependent upon You for support. [Emphasis added.]

SCHEDULE OF COVERAGE

COVERED PERSONS	Employees and Dependents, if elected
Child Age Limit:	Age 19, covered through the end of the month in which the age limit is reached.
Student Age Limit:	Age 25, covered through the end of the month in which the age limit is reached.

Denver/Boulder/Longmont Group Enrollment /Change Form

HOW TO COMPLETE THIS FORM

Section B – Family Information (Complete if you are enrolling or deleting eligible dependents.)

- *Your plan covers children only up to a certain age, unless a child is disabled or a full-time student at a college, university, or trade school.*

Form:	Date:
CO-POS-2007	2007

GC-2T-SCH-2007CO	1/22/2007
0106-0046-02-r07	07

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-102 and 10-16-104.3, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly define an eligible dependent in accordance with Colorado insurance law.

Issue E8: Failure of the Company to properly allow for assignment of benefits.

Section 10-16-106.7., C.R.S., Assignment of health insurance benefits, states in part:

> (1)(a) *Any carrier that provides health coverage to a covered person shall allow, but not require, such covered person under the policy to assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist as described in section 6-1-707 (1) (c), C.R.S., or a massage therapist, also referred to in this section as the "provider", for services provided to the covered person that are covered under the policy.*[Emphasis added.]

It appears the Company is not in compliance with Colorado insurance law in that its certificate of insurance for its triple option POS plan, (Colorado Added Choice Coverage), includes a provision that states the Company has the option of paying benefits to a person or institution on whose charges a claim is based, unless the covered person submits, in writing, a direction to the Company to pay benefits directly to the covered person. In addition, the form provides that benefits for covered medical transportation services are payable only to the provider of the services. As stated above, Colorado insurance law "allows", but does not "require" a covered person to assign payment of benefits to providers. The Company's form states in part:

CLAIMS PROVISIONS

Payment of Benefits

Benefits will be payable to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Covered Person immediately upon receipt of due written proof of loss. *Unless, however, the Covered Person directs otherwise in writing, KPIC has the option of paying all or part of such benefits directly to a person or institution on whose charges a claim is based.* [Emphasis added.]

A Covered Person may also authorize KPIC to pay benefits directly to a person or institution on whose charges a claim is based. Any such payments will discharge KPIC to the extent of payment made. Unless allowed by law, KPIC's payments may not be attached, nor be subject to, a Covered Person's debts.

Any benefits for health expenses for covered medical transportation services are payable to the provider of these services. No benefits are payable to the Covered Person to the extent benefits for the same expenses are paid to the provider. [Emphasis added.]

Form:	Date:
CO-POS-2007	2007

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.7, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to reflect correct information regarding assignment of benefits in accordance with Colorado insurance law.

Issue E9: Failure of the Company to properly define pre-authorization procedures.

Section 10-16-705., C.R.S, Requirements for carrier and participating providers, states in part:

> (14) Every contract between a carrier or entity that contracts with a carrier and a participating provider for a managed care plan that requires preauthorization for particular services, treatments, or procedures shall include: .[Emphasis added.]
>
> (a) *A provision that clearly states that the sole responsibility for obtaining any necessary preauthorization rests with the participating provider that recommends or orders said services, treatments, or procedures, not with the covered person*; and [Emphasis added.]

It appears the Company is not in compliance with Colorado insurance law in that its certificate of insurance for its triple option POS plan, (Colorado Added Choice Coverage) which includes a network of participating providers, includes a provision contradictory to the statute above, in that it penalizes the covered person for any lack of pre-certification. The Company applies a twenty percent (20%) reduction of benefits to covered charges incurred in connection with any service for which pre-certification was not obtained. The amount of the reduction is also not applied to the covered person's deductible, coinsurance or out-of-pocket maximum. Pre-certification is not the responsibility of the Covered Person and therefore no penalty may be incurred by a Covered Person when pre-certification is not obtained. While this statute is addressing the provisions of provider contracts, the Company may not include a provision in its form that contradicts this statute.

The Company's form states in part:

> **Precertification through Medical Review Program**
>
> This section describes:
>
> 1. The Medical Review Program and Pre-Certification Procedures
> 2. How failure to obtain Pre-certification affects coverage.
> 3. Pre-certification administrative procedures; and
> 4. Which clinical procedures require Pre-certification
> 5. How to appeal an adverse determination by the Medical Review Program; and
> 6. The Independent External Review Process
>
> *If pre-certification is not obtained, benefits for all Covered Charges incurred in connection with any service will be reduced by 20 percent each time Pre-certification is required. This 20 percent reduction will not count toward any Deductible, Coinsurance, Out-of-Pocket Maximum applicable under the Group Policy.* [Emphasis added.]

Form:	Date:
CO-POS-2007	2007

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-705, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to indicate that pre-authorization requirements are the responsibility of the participating provider that orders or recommends the service, in accordance with Colorado insurance law. It is recommended that the Company perform a self-audit to identify and correct any possible negative consumer impact resulting from its practices.

CANCELLATIONS/DECLINATIONS/TERMINATIONS

Issue H1: Failure of the Company's Certificates of Creditable Coverage to reflect the full definition of a "significant break in coverage".

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule*. [Emphasis added]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, states in part:

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

Section 5. Rules

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.

3. Application of the rules regarding breaks in coverage can vary between issuers located in different states, and between fully insured plans and self-insured plans within a state. The laws applicable to the health coverage plan

that has the pre-existing condition exclusion will determine which break rule applies.

4. Certifying creditable coverage

   Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance *must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation.* [Emphasis added]

SMALL GROUP CANCELLATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
102 (Small Groups)	138 (Individuals)	138	100%

It appears the Company is not in compliance with Colorado insurance law in that the letter it sends to members of cancelled small groups as a certificate of creditable coverage titled "Health Insurance Certificate of Creditable Coverage" doesn't reflect the full definition of "significant break in coverage" as provided in Section 4. A. of Colorado Insurance Regulation 4-2-18. Such full definition is required under Section 5. B. 4. The Company provided electronically reproduced copies of letters sent to 138 members of ten groups randomly selected from the sample of fifty (50) cancelled groups reviewed. None of the certificates reviewed include the required reference to a significant break in coverage.

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-118 C.R.S. and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its certificates of creditable coverage to reflect the full definition of a significant break in coverage as required by Colorado insurance law.

Issue H2: Failure of the Company's certificates of creditable coverage to disclose the name of the entity that provided coverage.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule*. [Emphasis added]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, states in part:

Section 2. Purpose and Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 2004 amendments to this regulation is to make clarifications and allowances to *ensure Colorado consumers receive correct certificates of creditable coverage in a timely manner.*

Section 5. Rules

A. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., *shall be as set forth in the federal regulations incorporated below.*

2. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, *Colorado law shall prevail.*

3. *The following sections of the federal regulations, adopted by the U.S. Department of Health and Human Services, are hereby incorporated by reference and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S.:* 45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124(b). *These sections concern* the method for counting creditable coverage; *requirements for providing*

> *certificates of creditable coverage to those who were insured under group plans, including the form and content of the certificates;* and requirements for providing certificates of creditable coverage to those who were insured under individual plans, including the form and content of the certificates. [Emphases added.]

B. Colorado law concerning creditable coverage.

1. *The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.*

…

4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation. [Emphases added]

45 C.F.R. 146.115, Certification and disclosure of previous coverage, states in part:

(a) Certificate of creditable coverage

(3) Form and content of certificate.

(ii) Required information. The certificate must include the following

(B) The name of the group health plan that provided the coverage described in the certificate; [Emphases added.]

SMALL GROUP CANCELLATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
102 (Small Groups)	138 (Individuals)	138	100%

The examiners reviewed a total of 138 certificate of creditable coverage (COCC) notices issued by the Company during the examination period. These 138 COCC's were included in ten (10) small group cancellation files that had been randomly selected as a sub-sample from the fifty (50) small group cancellation files randomly selected from the total population of files. The Company had requested that the examiners review the COCC's from only a sub-sample of cancellation files due to the large amount of time that would be required to produce all COCC's for all files, and due to the fact the information provided in the sub-sample would be representative of all COCC notices issued by the Company.

It appears the Company is not in compliance with Colorado insurance law in that none of the 138 notices titled "HEALTH INSURANCE CERTIFICATE OF CREDITABLE COVERAGE" identified Kaiser Permanente Insurance Company as the Company that provided the coverage described in the certificate.

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-118 C.R.S. and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its certificates of creditable coverage to include the Company's name as the provider of coverage in accordance with Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier. [Emphases added.]

ELECTRONIC CLAIMS PROCESSED OVER 30 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
157*	50	3	6%

(*<1% of all electronic paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) electronic claims from a total summarized population of 157 electronic claims that had not been paid, denied or settled within thirty (30) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that three (3) of the electronic claims in the sample, while appearing to be clean claims, were not paid, denied, or settled within thirty (30) calendar days after receipt.

NON-ELECTRONIC CLAIMS PROCESSED OVER 45 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
31*	31	1	3%

(*<1% of all non-electronic paid and denied claims)

The examiners reviewed the entire population of thirty-one (31) non-electronic claims that had not been paid, denied or settled within forty-five (45) calendar days after receipt. It appears that the Company is

not in compliance with Colorado insurance law in that one (1) of the non-electronic claims in the sample, while appearing to be clean claims, were not paid, denied, or settled within forty-five (45) calendar days after receipt.

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
7*	7	5	71%

(*<1% of all paid and denied claims)

The examiners reviewed the entire population of seven (7) claims that had not been paid, denied or settled within ninety (90) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that five (5) of the claims in the sample did not appear to involve fraud, but were not paid, denied or settled within the required ninety (90) calendar days after receipt.

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all claims are paid, denied, or settled within the time frames required by Colorado insurance law.

Issue J2: Failure, in some instances, to pend unclean claims and to allow the required time for submission of additional information before denying.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

> (4)(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after the receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. *Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b) subject to resubmittal of the claim or the appeals process.* If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4). [Emphases added.]

CAIMS DENIED DUE TO MISSING INFORMATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
823*	50	7	14%

(*7% of all paid and denied claims)

Using ACL™ software, the examiners identified a summarized population of 823 claims denied during the period under examination. A random sample of fifty (50) such claims was selected for review. It appears that the Company was not in compliance with Colorado insurance law in that there were seven (7) files out of fifty (50) reviewed where the Company improperly denied the claim instead of notifying the claimant of what additional information was needed to resolve the claim and allowing the required time for the information to be submitted prior to denying these claims.

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that any claims that require additional information are pended and held open for the required time period for the additional information to be submitted as required by Colorado insurance law

Issue J3: Failure, in some instances, to provide notice of appeal rights on denied claims.

Section 10-16-113, C.R.S., Procedure for denial of benefits – rules, states in part:

> (1) (a) A health coverage plan shall not make a determination, in whole or in part, that it will deny a request for benefits for a covered individual on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.
>
> (c) If a health coverage plan denies a benefit because the treatment is an excluded benefit and the claimant presents evidence from a medical professional licensed pursuant to the "Colorado Medical Practice Act", article 36 of title 12, C.R.S., or, for dental plans only, a dentist licensed pursuant to the "Dental Practice Law of Colorado", article 35 of title 12, C.R.S., acting within his or her scope of practice, that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit, such evidence establishes that the benefit denial is subject to the appeals process. The denial of such benefit shall be subject to the appeals provisions of this section and section 10-16-113.5.
>
> (2) *Following a denial of a request for benefits by the health coverage plan, such plan shall notify the covered person in writing. The content of such notification and the deadlines for making such notification shall be made pursuant to regulations promulgated by the commissioner.* [Emphases added.]

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 2 Background and Purpose

> *The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of Sections 10-3-1104(1)(h), 10-16-409(1)(a), and 10-16-113, C.R.S., in situations involving* utilization review and *certain denials of benefits for treatment, as described herein.* Among other things, Section 10-3-1104(1)(h), C.R.S., requires carriers to adopt and implement reasonable standards for the prompt investigation of claims arising from insurance policies; promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and refrain from denying a claim without conducting a reasonable investigation based upon all available information. This regulation replaces Colorado Emergency Regulation 05-E-5 in its entirety.

Section 4 Definitions[1]

> A. *"Adverse determination"* means a determination by a health carrier or its designee that request for a benefit has been reviewed and, based upon the

information provided, does not meet the health carrier's requirement for medical necessity, or is determined to be experimental or investigational, and is therefore denied, reduced, or terminated. An adverse determination *also includes a denial for a benefit excluded by a health coverage plan for which the claimant is able to present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit.*

Section 5 Compliance Requirements

E. A health carrier that does not allow an appeal, consistent with the procedures set forth in this regulation, of a benefit denial for a treatment excluded by the health coverage plan when the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based upon all available information. (Section 10-3-1104(1)(h)(IV), C.R.S.)

Section 6 Standard Utilization Review

A. A health carrier shall maintain written procedures pursuant to this section for making utilization review decisions and for notifying covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.

C. Retrospective review determinations.

1. *For retrospective review determinations,* a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the benefit request. If the determination is an adverse determination, *the health carrier shall provide notice of the adverse determination to the covered person in accordance with Subsection E.*

E. Requirements for adverse determination notifications.

1. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

a. An explanation of the specific medical basis for the adverse determination;

b. The specific reason or reasons for the adverse determination;

c. Reference to the specific plan provisions on which the determination is based;

d. A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;

e. If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

f. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

g. If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph e. of this paragraph; or

(ii) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph f. of this paragraph; and

h. A description of the health coverage plan's review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision;

2. A health carrier must provide the notice required under this section in writing, either on paper or electronically.

DENIED CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
72	50	43	86%

As a result of a referral received from the Division's Consumer Affairs section, the examiners requested a supplemental sample of fifty (50) claims denied during the period under examination with denial reason code 017 – "Under your plan, this service is not covered". It appears that the Company is not in compliance with Colorado insurance law in that forty-three (43) files out of fifty (50) claims reviewed appeared to be subject to the appeal notice requirements outlined in the above statute, but did not include evidence of the required notification to members of their appeal rights.

In addition, the Company indicated in response to an inquiry from the examiner that it did not provide the required notice of appeal for any claims that were denied during calendar year 2007.

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-113 C.R.S and Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has reviewed and modified its procedures to ensure that members receive notice of their appeal rights in compliance with Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS	Rec. No.	Page No.
OPERATIONS AND MANAGEMENT		
Issue A1: Failure, in some instances, to maintain and to provide, upon request, records and documents required for market conduct purposes.	1	17
CONTRACT FORMS		
Issue E1: Failure of the Company's forms, in some instances, to provide coverage for a newborn or adopted dependent to the extent required by Colorado insurance law.	2	20
Issue E2: Failure, in some instances, to include correct eligibility requirements in the certificate of insurance.	3	22
Issue E3: Failure of the Company's forms, in some instances, to include Medicare eligible employees as being eligible for coverage.	4	24
Issue E4: Failure of the Company to properly define termination requirements in its membership agreements.	5	27
Issue E5: Failure of the Company to include a provision for coordination of benefits with Medicare that complies with Colorado insurance law.	6	30
Issue E6: Failure of the Company's forms, in some instances, to reflect correct information regarding eligibility for conversion coverage.	7	34
Issue E7: Failure of the Company to properly define an eligible dependent.	8	37
Issue E8: Failure of the Company to properly allow for assignment of benefits.	9	39
Issue E9: Failure of the Company to properly define pre-authorization procedures.	10	41
CANCELLATIONS/DECLINATIONS/TERMINATIONS		
Issue H1: Failure of the Company's Certificates of Creditable Coverage to reflect the full definition of a "significant break in coverage".	11	44
Issue H2: Failure of the Company's certificates of creditable coverage to disclose the name of the entity that provided coverage.	12	47
CLAIMS		
Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.	13	50
Issue J2: Failure, in some instances, to pend unclean claims and to allow the required time for submission of additional information before denying.	14	51
Issue J3: Failure, in some instances, to provide notice of appeal rights on denied claims.	15	55

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